NEWS

Doctors battle to contain cholera in Rwandan camps

As cholera continues to rage through the refugee camps in and around the Zairean border town of Goma over 200 expatriate doctors and nurses are now working in the region for the medical aid agency Médecins Sans Frontières. It is the largest contingent ever deployed by the agency in a disaster area at one time. Most of the volunteers are working in the Goma region. Further teams are active in refugee camps in Rwanda, Burundi, and Tanzania. As the death toll from cholera continues to rise, however, the agency is appealing for more volunteers.

The agency's clinics, which were originally opened in Goma and along its access roads to deal with all types of medical problems, are now working full time to stem the cholera epidemic. Other medical problems such as severe malnutrition, particularly among orphaned children, have begun to take their toll. "The children are no longer helped by other refugees. Everyone has their own problems now," said Victoria Godsal of Médecins Sans Frontières. "Cases of measles are also on the increase."

Maurice Herson of Oxfam, who recently returned from Goma, also expects an imminent rise in skin, respiratory, and eye diseases. "Not only is there little or no water for washing but the refugees have now begun burning green wood. A constant pall of smoke hangs over the region."

But dysentery and cholera continue to be the main concerns. Both were already endemic in the region before the refugees began arriving nearly three weeks ago, and the lack of latrines and water sources for over one million people has fuelled the tragedy. It is thought that tens of thousands of latrines need to be drilled into the region's hard volcanic rock, while technical teams struggle to neutralise and then chlorinate the heavily alkaline water in the two main river sources.

Meanwhile, some survivors are now beginning to trickle back to Rwanda. British doctors Peter Hall and Andrew Carney, working for Physicians for Human Rights, UK, recently returned from Rwanda, where up to half of the population has died, been internally displaced, or has fled.

The doctors' mission included an assessment of the psychological effects on the population of the recent genocide, thought to have killed over 500 000 people. After interviews with 250 Rwandan people, and using a World Health Organisation self report questionnaire, the doctors estimate that over 90% of the population can be considered to be significantly psychologically affected.

GAMMA/SPOONER

Tragedy in Rwanda: volunteers are needed

At one hospital they visited there were no staff and only 25 of 250 psychiatric patients remained. A mass grave was found nearby, and human remains were found in the hospital itself, which had been taken over by refugees. Dr Carney, a psychiatrist at Harperbury Hospital near St Albans, set up an impromptu clinic after patients brought him their medication cards. Most hospitals, however, continue to function, albeit at a reduced capacity.

The doctors also visited orphanages, where some children were too traumatised to speak. "One 12 year old girl went out to get water and came back to find her mother had been disembowelled, her father had had his throat slit, and all her siblings were dead. She went to her grandmother's and found all her family dead too. So she hid in the bush for three weeks until a United Nations worker found her," said Dr Carney. A 5 year old had been raped and another girl speared in the chest. Two sisters had been found hidden under a pile of dead bodies. "And this was only one small orphanage," said Dr Carney. The two doctors said that they had also gathered evidence of human rights violations against and by members of the medical profession.

Dr Hall, a physician at Leavesden and Watford Hospitals, said: "The new government is very anxious for the refugee population to return, and we found no evidence to suggest that they would be badly treated if they did."—LOUISE BYRNE, freelance journalist, London

Use of fetal eggs for infertility treatment is banned

Eggs from aborted fetuses and cadavers should not be used to treat infertile women in Britain, although they can be used for research, said the Human Fertilisation and Embryology Authority (HFEA) last month. The authority, which licenses fertility clinics, made its ruling after six months of public consultation on the use of donated ovarian tissue. The authority received nearly 10 000 responses to its consultation document—83% were against using fetal eggs for infertility treatment. More than half the responses were in favour of using fetal eggs for research.

The HFEA said that only ovarian tissue from live, consenting donors would be acceptable for treatment. "While we have no objection in principle to the use of cadaveric ovarian tissue from adult women, we will not currently approve its use," said the authority. Sir Colin Campbell, chairman of the HFEA, said that they would be willing to review the issue in the future. "We do not think we need to act on this with urgency," he said. "It is not just an issue of having an organ card and donating an organ to save a life. This would involve donating tissue that has the potential of making life."

The authority rejected the use of fetal

Headlines

Doctor wins racial discrimination case against NHS: Dr Tariq Ahmed Mian has won a racial discrimination case against the NHS after he failed to be shortlisted for a training post as a registrar in public health in Edinburgh, although he had two postgraduate degrees in the specialty. Dr Mian, who qualified in the Punjab, and is British, has been unable to find a training post because of having limited registration with the General Medical Council.

Injured nurse wins £205 000: A British nurse has won damages of £205 000 in a settlement reached between the Royal College of Nursing and Hounslow and Spelthorne Health Authority. Mrs Fiona Boag was seriously hurt while helping to move a patient.

WHO sends teams to Rwanda: The World Health Organisation has sent teams of epidemiologists to the Zaire and Rwanda border. By collecting stool samples for analysis they will identify the strain of cholera and determine which antibiotics should be used for the most severely affected cases.

US president will be flexible over health reforms: The United States president, Mr Bill Clinton, has said that he would not veto a healthcare bill that "moved toward universal coverage," which is his goal. He is sceptical of Mr Robert Dole's alternative insurance reform proposal. Without universal coverage Mr Clinton said that it would be unworkable because it would result in higher cost for most workers.

NHS funds only 5% of private admissions: In 1992-3 only 4·9% of private hospital admissions were funded by the NHS, according to the annual *Laing's Review* of Private Healthcare, 1994. On the other hand, independent providers face competition from the NHS share of the private market, which grew from 11·2% in 1988 to 13·4% in 1993.

Children's coaches will have seatbelts: The British government is to make seatbelts compulsory on coaches and minibuses used to carry children after a series of accidents in which children were killed. It will also urge the European Commission to require belts to be fitted to all new coaches and minibuses which operate in the community.

ovarian tissue for treatment on the grounds that it was unsafe and that there could be damaging psychological effects on a child conceived in this way. Sir Colin said: "The technology to carry out this treatment is 10 years away, but as it stands we think that it would be dangerous for women to receive fetal tissue. We also do not know enough about the development of eggs from fetal ovaries to know how safe it would be. New developments such as taking immature eggs from live donors and helping them to grow will reduce the need for fetal tissue."

Jeannette Naish, a general practitioner and member of the HFEA, said that public revulsion was so strong that it was an important consideration in whether fetal ovarian tissue should be used to treat infertility. "We don't know what the psychological effects on children will be because it hasn't happened yet," she said. "It is possible that these children could be treated as lepers or pariahs. These are very new ethical and legal debates, and we don't want to rush into them without careful debate."

Susan Golombok, professor of psychology at City University, London, who has carried out research for the HFEA, said that little was known about the psychological effects on children born from live egg and sperm donations. Her research suggests that parents who have had assisted conception are not telling their children. "Unlike adopted children there is a feeling that these children can be given no information on their biological parents," she said. "They will never be able to trace them. Their parents feel that it's better for them not to know.

"But it is not inconceivable that children who have been born from the eggs of a dead donor could cope with that information. Adopted children have to assimilate that they were born to someone who then gave them away. At least these children would know that they came from the egg of someone who wanted to donate that egg—in that sense they would always have been wanted."

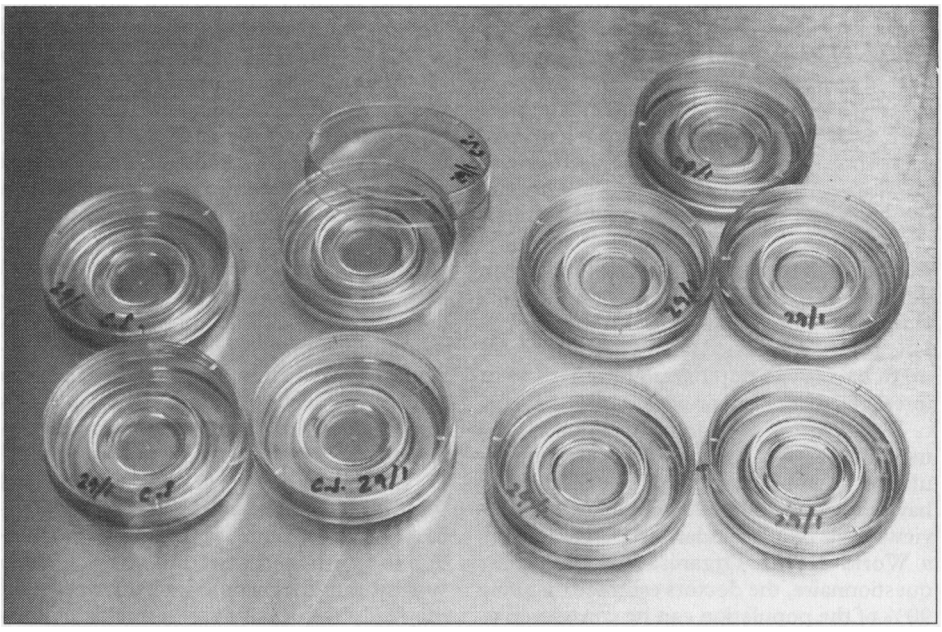
The authority's ruling is in line with a bill introduced by Jill Knight, a conservative member of parliament, that bans the use of eggs from fetuses for "fertilisation procedures." The measure was introduced as an amendment to the Criminal Justice Bill and is likely to pass into law later this year. Dame Knight said that she wanted to send a message to scientists "that there is no point in spending any more time in research in that area, or in messing about with aborted mouse eggs. . . . The end product from using aborted human eggs for fertilisation purposes will simply not be allowed to be used."

But Sir Colin said that research would continue because it could produce great benefits. "It can help to find better ways of treating infertility; and it can help to avoid the passing on of some devastating inheritable disorders," he said. "We will not be letting scientists play around with embryos—they will have to show that the research they carry out will be for discernible benefit."

The conclusions of the HFEA fall short of what the BMA had suggested in its response to the consultation document. "We support the HFEA's view in allowing the use of cadaveric ovarian tissue but are concerned that it is not allowing its use for infertility treatment," said Dr Fleur Fisher, head of ethics at the BMA. "We support their conclusions that the use of fetal ovarian tissue in treatment is not acceptable at present."

In its third annual report, also published last month, the HFEA said that 18 224 in vitro fertilisation treatment cycles were given to 13 791 women in 1992. There was a success rate of 12.7%—slightly down from the 1991 figure of 13.9%. The report suggests that this is due to an increase in the age of recipients and an increase in the use of frozen embryos, which has a lower success rate.—LUISA DILLNER, *BMJ*

Donated Ovarian Tissue in Embryo Research and Assisted Conception is available free from the HFEA, Paxton House, 30 Artillery Lane, London E1 7LS.



DOHRN/SPL

Research into infertility – not much is known about the effects of egg donation on offspring

London scientists blame NHS reforms for brain drain

An exodus of top medical researchers from London to posts elsewhere in Britain and abroad is being blamed on government mismanagement of the NHS. The brain drain includes several leading figures in genetics and gene therapy. Among them is Professor Bob Williamson, famous for his part in the discovery of the gene for cystic fibrosis. He is leaving St Mary's Hospital to take up a post as professor of genetics at Melbourne University in Australia.

Professor Williamson said that he had always resisted headhunting offers in the past but that things had "gone far enough" in London's hospitals. He said that the commercialisation of the NHS had made research all but impossible in London. "Research needs cooperation between the centres involved, but what we have now is hospitals competing, for patients and money." He said that many junior consultants were also frustrated and considering leaving.

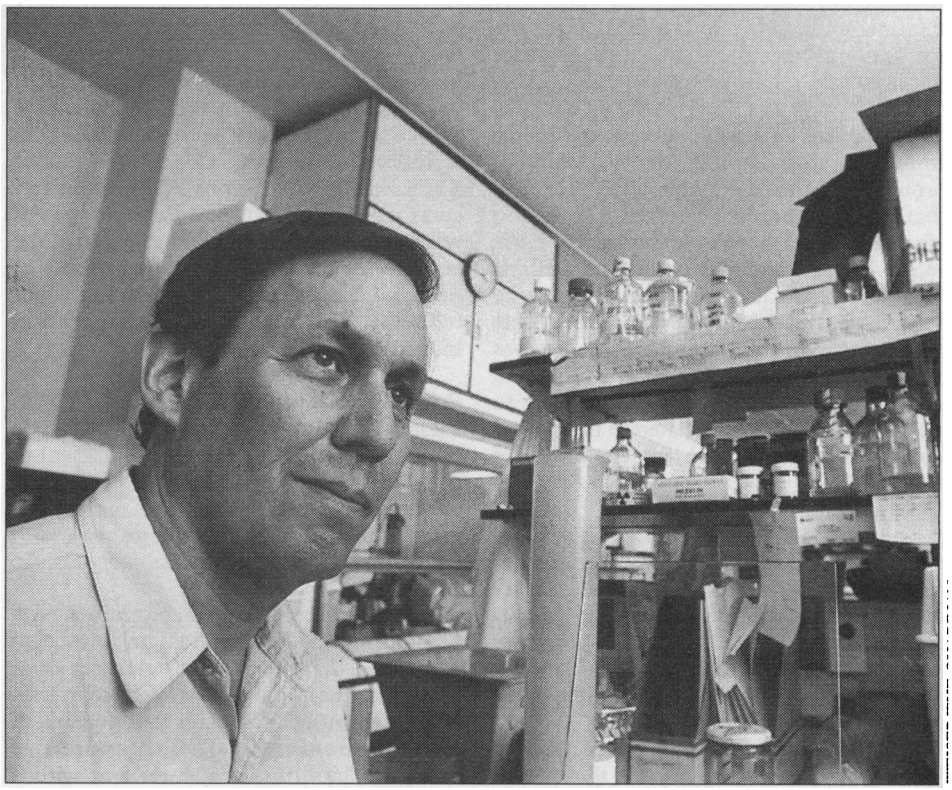
"Ten or 15 years ago people would put up with the expense and inconvenience of London because of its clinical and academic excellence. Now there is far less cooperation between different hospitals because they are run by competing trusts. Obviously there is a major disruption in training and research."

Professor Williamson is the latest in a line of noted researchers who have announced their decision to leave the capital. Hospitals that are due for merger, such as the Hammersmith (with Charing Cross) and Guy's and St Thomas's, seem to suffer from particularly low morale. Professor Kay Davies, who was to have been director of the Medical Research Council's £21m clinical sciences centre at Hammersmith Hospital, has instead resigned and returned to her former job as head of molecular genetics at the Medical Research Council's Institute of Molecular Medicine in Oxford. Professor Michael Chapman, pioneer in fetal heart surgery, left Guy's Hospital in March for St George's Hospital in Sydney, Australia. Dr David Bihari, director of the intensive care unit at Guy's Hospital, has said that he too will go to St George's if the government's plans for his hospital go ahead.

Professor Lucio Luzzatto, head of haematology at Hammersmith Hospital and a leading expert in sickle cell anaemia and thalassaemia, has gone to New York, where he is setting up a genetics department at the Sloane Kettering Memorial Hospital. Tim Eden, professor of paediatric oncology at St Bartholomew's Hospital, is to leave in October. He will take up the Cancer Research Campaign chair at the Royal Manchester Children's Hospital. Barts will also lose Professor Richard Wood, a leading kidney surgeon, to the Northern General Hospital in Sheffield.

Although the scientists did not discuss their resignation plans with one another beforehand, they decided to present a common front to the press once the story came out. "We didn't want the papers saying 'Charing Cross loses top doctor' or anything like that," said Professor Williamson. "That would have damaged Charing Cross or whatever hospital it was, and that's what we want to prevent. Rather we want to show that it's a London-wide problem, one that stems from the government's policies."

Sir William Stewart, the government's chief science adviser, acknowledged that headhunting by foreign institutes would exist as long as Britain continued to produce outstanding scientists. But he argued that it was a two way process, citing the case of an American medical research team recently seduced from Johns Hopkins University in Maryland by Cambridge.—OWEN DYER, freelance journalist, London



Professor Williamson: believes things have "gone far enough" in London's hospitals

Judge allows force feeding of mentally competent patient

The Mental Health Act 1983 allows detained patients to be treated against their will even if they are mentally competent to refuse treatment and the treatment is against their best interests, a High Court judge ruled last week. Mr Justice Thorpe granted Croydon Health Authority a declaration that it could force feed a 24 year old detained patient suffering from borderline personality disorder.

The judge made the declaration despite deciding that the patient was competent to refuse treatment and that force feeding would not be in her best interests "unless and until her physical state was so debilitated as to threaten her survival." He said that it was "disquieting" that the act legalised what the common law would not.

Lawyers for the patient, named only as Miss B, said that they would appeal. Her solicitor, Lucy Scott-Moncrieff, described the result as "a very sinister development," adding: "It means that a doctor can give someone treatment for one condition which will make his or her underlying psychiatric condition worse." Miss B's counsel, Richard Gordon QC, said: "This must be the first case ever where a patient has been declared to be competent and it's said to be contrary to the patient's best interests for the patient to be treated, yet the treatment is allowed to go ahead."

Miss B, detained in a locked ward at Warlingham Park Hospital near Croydon, was sexually abused by her grandfather from the age of 6 to the age of 10 and has a compulsion for self harm by burning with cigarettes, cutting herself, and—since these means were removed—limiting her food intake. She is receiving no psychotherapy or other treatment and sought a High Court declaration banning doctors from feeding her by nasogastric tube.

Mr Justice Thorpe rejected her counsel's argument that nasogastric feeding was not treatment for mental disorder under the Mental Health Act. He was satisfied that she had the capacity in her present state to refuse artificial feeding. If he was wrong in that conclusion, he said, it would be necessary to consider whether such feeding was in her best interests. This should be assessed in accordance with acceptable medical practice. Force feeding would magnify her disorder and reduce the prognosis for the only recognised treatment, psychoanalytic psychotherapy. Miss B was driven to her current position by a restrictive caring regimen and the absence of any present or proposed

treatment plan, the judge said. Had she received the treatment that her disorder required she might not be in her present conflict.

The health authority had rejected advice from a psychiatrist with analytic training, brought into the case at the judge's request, that Miss B should be referred to a unit where she could receive psychotherapy. That seemed to approach the boundary at which the proposed medical treatment ceased to be acceptable. But the judge said that the effect of section 53 of the Mental Health Act was "to limit the autonomy of the detained patient whose capacity is unimpaired to treatments that are not related to the mental illness or disorder for which they are detained."

Granting the health authority a declaration that doctors could force feed the patient, he said that he had been tempted to require the authority to use its best endeavours to secure Miss B's admission to a specialist unit. But he accepted that since the authority sought no more than a declaration as to statutory rights it would not be appropriate to attach conditions.

Paul Aitchison, unit general manager of Warlingham Park Hospital, said that he had not yet seen the judgment. "Our primary concern is to keep her alive against her wishes. We have considered treatment, but we're guided by medical staff and the consultant as to the timing and suitability of transfer."—CLARE DYER, legal correspondent, *BMJ*

Government acts on gifts from drug companies

Expensive gifts, such as medical equipment and expenses paid foreign trips, from drug companies to doctors will be banned under parliamentary regulations laid last week. Drug companies have failed to abide by rules laid down by the Association of the British Pharmaceutical Industry, and drug company staff who offer sales inducements to doctors could face criminal charges. Doctors could also be found guilty of accepting inducements. Doctors have been criticised for accepting free air tickets to conferences to cover holiday travel costs and for accepting luxury trips to Venice and Monte Carlo.

The regulations make it clear that hospitality, including travel and accommodation, offered at promotional conferences must be reasonable and subordinate to the main purpose of the meeting. Hospitality cannot be extended to spouses. Inexpensive items are allowed under the regulations, which implement a European directive on the advertising of medicines. Health minister Mr Tom Sackville said, "Any attempt by drug companies to influence doctors' prescribing habits by means of financial or other inducements is to be deplored."

The regulations follow a recent ruling (26 March, p 810) that two drug companies had "discredited" the pharmaceutical industry by offering doctors money, gifts, and inappropriate hospitality to promote sales of their products. The ruling was made in March by the industry's watchdog, the Prescription Medicines Code of Practice Authority, against Fisons Pharmaceuticals and Duphar Laboratories. Both companies were found to have breached a section of the code of practice which says that methods of promotion must never bring discredit on, or reduce confidence in, the pharmaceutical industry.

A spokesman for the Association of the British Pharmaceutical Industry said that the association would carry on with its own code of practice, which it considered sufficient to deal with the problem. He said: "We have always said and still believe that the government's planned legislation is unnecessary. We do not believe that criminal sanctions are needed."

The Commons health committee, in a separate report last week, said that it was not convinced that the present voluntary code on the marketing of drugs to doctors was being rigorously applied, or that policing of it should be entrusted to a body answerable solely to the drug companies and with a vested interest in protecting them from criminal proceedings.

The committee recommends that the code of practice authority should be widened to include members nominated by the Department of Health, the BMA, and consumer groups to re-examine the code and to establish whether breaches are being penalised with sufficient rigour.

The government regulations will also allow the Medicines Control Agency in certain circumstances to refer complaints about advertisements to the relevant self regulatory body. The agency, however, will retain statutory enforcement powers. The regulations come into effect from 9 August.—LINDA BEECHAM, *BMJ*

Surgeon pleads guilty to risking patients' health

A surgeon who performed operations knowing that he was a hepatitis B carrier faces a possible jail sentence after being convicted last week of causing a public nuisance. In what is thought to be an unprecedented case, Dr Umesh Gaud, aged 40, who worked at two London hospitals, pleaded guilty at Southwark crown court to knowingly endangering patients' health during heart and chest operations. Dr Gaud, of Mile End, east London, is believed to have infected three patients at the Royal London Hospital, where he was a senior house officer, and three at the London Chest Hospital, where he was a registrar.

The charge stated that between 20 August 1990 and 4 October 1993 he caused "a nuisance to the public by endangering the health of the public by performing or assisting in the performance of invasive surgery at various hospitals knowing you were a carrier of the hepatitis B virus and were HBsAg and HBeAg positive."

He pleaded not guilty to two charges of obtaining a pecuniary advantage by deception—by falsely representing that he had no medical condition which would affect his employment when he applied for posts in cardiothoracic surgery and that his curriculum vitae contained accurate information about previous employments—but the charges were left on the file. Dr Gaud will return to court for sentencing on 29 September. Under common law he could be given an unlimited jail sentence or an unlimited fine.

The judge, Mr Justice Blofield, told the prosecution counsel, Victor Temple QC: "I would like you on 9 September to be in a

Doctors at a conference in the Carribean

position to inform the court whether there has ever been a prosecution of this nature in this country before." Temple is likely to have difficulties in finding precedents. The closest is thought to be in 1815, when a woman who wheeled a baby infected with smallpox through the streets was convicted of causing a public nuisance.

Dr Gaud was immediately suspended last October when his condition was discovered, and he was counselled against further clinical activity. He also faces disciplinary proceedings by the General Medical Council. Guidelines issued by the Department of Health last August require all staff involved in surgery to be immunised against hepatitis B and all carriers to be banned from operating.—CLARE DYER, legal correspondent, *BMJ*

MULVEHILL/SPL

Radical changes are being proposed to control the NHS drugs budget

MPs want more people to pay for prescriptions

Radical changes in the way that the NHS controls its £3.3bn annual drugs budget are proposed in a report from the Commons health committee. The proposals range from creating a national prescribing list to allowing fewer exemptions from prescription charges.

Tighter controls are also proposed on the prescribing behaviour of general practitioners, subject to all patients being entitled to receive the drugs that they need. The government is urged to introduce sanctions against underprescribing, which the committee says can be just as harmful to patients as overprescribing. It calls for doctors' target budgets to be based on capitation to take account of social deprivation, to encourage generic prescribing as well as a "tick in" system. In addition, it proposes that every family health services authority should adopt a model formulary for the guidance of local practices.

The main recommendations, however, are on three aspects of cost control: the pharmaceutical price regulation scheme (PPRS), the selected list, and prescription charges. The committee suspects that the PPRS tilts unfairly to the benefit of the drug companies, with the large multinationals manipulating it to their own advantage. The MPs recommend that the PPRS should be reviewed after five years to decide whether or not it should be retained. In the meantime it should be opened up to public scrutiny, with an annual report to parliament giving the profit targets negotiated between individual companies and the Department of Health.

Supporting the principle of a selected list of drugs that may not be prescribed under the NHS, the report suggests that it should be transformed from a blacklist to a "white list." Called a national prescribing list, it would contain a wide spectrum of products which the NHS was prepared to buy. All new drugs would be listed for five years but then excluded if found to have no therapeutic advantage. In this way a comprehensive national formulary would be built up over 10 years.

Two Labour members voted against the national list proposal, and on prescription charges the committee split evenly on party lines with the issue decided on the casting vote of the Tory chairman, Mrs Marion Roe. The main proposal is that free prescriptions should be available only to people on low incomes and to sufferers of chronic illnesses that call for lifelong medication.

A proposed review would aim at reducing the present £4.75 prescription charge but with fewer exempt categories—at present these include all children, pensioners, and pregnant women. The government is likely to welcome this as a contribution to a national debate on targeting welfare benefits.

The Association of the British Pharmaceutical Industry, opposing a national prescribing list, said that companies would not take the risk of their products being blacklisted after only five years, causing new medicines to be withheld from the British market.

Judy Gilley, deputy chairman of the BMA's general medical services committee, welcomed the concept of a "white list" as something worthy of consideration and said that much of what the committee proposed seemed reasonable.

But she voiced concern over the committee's suggestion that family health services authorities should have their own local formularies: "the quality of medical and pharmaceutical advice to these authorities varies enormously and I suspect that such advice might be based on economical rather than clinical need."—JOHN WARDEN, parliamentary correspondent, *BMJ*

Priority Setting in the NHS: The NHS Drugs Budget, second report of the health committee, is published by HMSO, price £11.40.

US tightens rules on vitamin claims

New labelling regulations introduced by the US Food and Drug Administration (FDA) will make it more difficult for the manufacturers of vitamins and other dietary supplements to make health claims on behalf of their products. Any claims printed on labels must now be supported by "significant scientific agreement among qualified experts."

The FDA has also announced further measures, to be introduced in a year's time. These will require all preparations that may contain vitamins, minerals, herbs, fish oils, amino acids and proteins, organ extracts, and other substances to include a nutrition information panel on the label giving the nutrient content per serving. Similar rules already apply for conventional processed foods.

All health claims on supplement labels must in future have gained the FDA's approval. The only two claims currently allowed are that calcium can help to prevent osteoporosis and that 0·4 mg of folic acid a day can reduce the risk of neural tube birth defects.

Several other health claims that have been approved for foods are not, however, allowed for supplements. These include the claim that antioxidant vitamins can reduce the risk of cancer, that dietary fibre can help to reduce the risk of colorectal cancer, and that ω-3 fatty acids in fish oils can help to prevent heart disease.

"We believe that the FDA erred in not also permitting these health claims for dietary supplements which contain these substances," said Annette Dickinson, director of scientific and regulatory affairs for the Council for Responsible Nutrition,

a trade association representing the dietary supplement industry.

The council wants more direct involvement of scientists studying these subjects in the development of the FDA's regulations. For example, contrary to the practice with drugs, no scientific committee was set up to advise the FDA on the merit of the claim that antioxidants can reduce the risk of cancer.

Any enforcement of these new regulations may, however, be weakened by pending legislation in Congress, which has been lobbied heavily by the dietary supplement industry, on the same subject. Two bills, which could supersede the new regulations, are in various stages and will eventually be fashioned into one consensus bill. The first is said to have a lot of support. It emphasises that dietary supplements help to prevent serious chronic diseases and will lower the nation's health care costs.

According to one member of the Congressional staff, this first bill would "deregulate the industry. Little substantiation of claims is called for." The second bill would require all health claims to be scientifically substantiated before being made.—GAIL MCBRIDE, medical journalist, Chicago

Denmark to tackle high goitre rate by adding iodine to salt

Denmark is considering introducing legislation making it compulsory to add iodine to salt after two studies found an extremely high rate of goitre.

The World Health Organisation recently estimated that 5% of Danish schoolchildren and 10% of adults had a goitre sufficient to raise their concentration of thyroid stimulating hormone, which it attributed to lack of iodine. Another study, based on the town of Randers, found that 12% of residents had a goitre.

The head of the National Food Committee's nutritional department, Lars Ovesen, said that 75% of adults could lack sufficient iodine, 50% could lack iron, 25% calcium, and 10% folic acid. He believes that this is due to recent changes in Danish dietary habits, in particular a switch away from fish—which used to be an extremely important local staple—and green vegetables, towards more meat and dairy products.

The committee is also considering making it compulsory to add calcium, iron, and folic acid to flour. This would be a new departure for Denmark, which—unusually in Europe—has almost no tradition of adding minerals and other substances to food. There is a strong public feeling that consumption of such substances should be a matter of individual choice and that food should be as pure as possible. Phosphorus and calcium were once legally required to be added to flour and grain, but this requirement was withdrawn several years ago. Today, the only mandatory additive is vitamin A in margarine, to make it comparable nutritionally with butter.

Mr Ovesen said that the level of deficiencies was unacceptable and so widespread that it would be impractical to tackle through health information campaigns alone. "It could be a problem to add iodine to table salt, because we have already recommended that people should reduce their consumption," he said. "One possible solution would be to add it to the salt that is used by bakeries to make bread." He also emphasised the need to confirm that the use of additives would not lead to some people acquiring undesirably high levels of minerals.—MARGARET DOLLEY, freelance journalist, Copenhagen

Focus: Westminster

Reshuffling the reforms

Virginia Bottomley stays and Brian Mawhinney goes. The cause and effect of last week's ministerial reshuffle, in as far as it affects the health service, is easily summed up. Dr Mawhinney's promotion to the cabinet as transport secretary ensured that Mrs Bottomley continues as secretary of state for health. For the prime minister to move both the number one and two at the health department would have been taking a gamble. Mawhinney was too good to stay; Bottomley was too valuable to be moved, and it is futile to speculate if some other arrangement should have prevailed. To fill the vacancy for health minister, Mr Major chose a careerist from the Conservative party network, Scots lawyer Gerry Malone, now MP for Winchester. Married to a consultant anaesthetist, Mr Malone arrived on his 44th birthday well versed in medicopolitics, where the decibels are increasing by the hour.

Continuity is therefore the watchword at Richmond House. Two weeks ago I characterised Mrs Bottomley as being singular among ministers in her unshaken optimism that the NHS reforms are succeeding. This she confirmed in subsequent testimony to the Commons health committee. The reforms, she said, are now part of the landscape rather than part of the debate. They were a means to an end and not an end in themselves. The task now, she said, is to harness their potential and "think radically" about the future of the NHS. Ambitiously, Mrs Bottomley believes that she is presiding over "the most coherent set of health policies of any country in the world."

Simultaneously her views were corroborated in an analysis by the Organisation for Economic Cooperation and Development (OECD), based in Paris (23 July, p 221). Mrs Bottomley's enthusiastic reception of the OECD report can be taken as a clue to where the reforms go from here.

Certainly, the secretary of state's preoccupations in the coming year will be with further decentralising of the NHS administration in England and the closure of hospitals in London and other cities. Downsizing is today's buzz word. The future shape of postgraduate medical education and training will become a dominant issue, prompted by the abolition of the regional tier. Plans will be enshrined in legislation for the next parliamentary session.

Above all, perhaps, is the threatened confrontation over local pay bargaining for doctors. Mrs Bottomley regards performance pay as no different in principle from long cherished merit awards. These are under review and look like becoming a negotiating tool in the discussions.

After the cabinet changes the chairman of the BMA council, Dr Sandy Macara, urged Mrs Bottomley to signal a fresh start by dropping her commitment to local pay deals. She demurred but still insists that Dr Macara is someone she can do business with. If so the outcome she foresees on pay is a hybrid arrangement, with local topping up of review body recommendations.

Two other details of the reshuffle deserve mention. David Hunt, former employment secretary, replaced William Waldegrave as Chancellor of the Duchy of Lancaster, with responsibility for science policy. But since Mr Hunt sees his main function as Mr Major's *chef de cabinet* the risk is that science policy, too, will be downsized.

Secondly, there was the appointment of the medical peer, Lord McColl, as the prime minister's first ever parliamentary private secretary in the House of Lords. The purpose is to strengthen the premier's relationship with the upper house, which is badly needed. but it also gives Lord McColl unique access to the prime minister. It is no doubt inevitable, from time to time, that conversation will turn to the health service and its reforms—of which there is no more committed supporter than Lord McColl. —JOHN WARDEN, parliamentary correspondent, *BMJ*